Salem Health
Hospitals & Clinics

Discharge Planning for Patients Hospitalized for Mental Health Treatment
Clinical Department Policy and Procedure

Applicable Campus	Department Name	Approval Authority
Salem Health	Psychiatric Medicine Center	System Director, Emergency and Clinical Support Operations

Effective Date: August 2021	**Next Review Date:** July 2024

List Stakeholders Position or Committee	Document Status	Date of Approval
Nurse Manager, PMC	Revised	06/2021
Manager, Regulatory and Patient Safety	Revised	06/2021
Director, Corporate Integrity Safety and Risk	Revised	07/2021
PMC Medical Director	Reviewed	07/2021
Nurse Manager, PMC	Reviewed	07/2021
System Director, Emergency and Clinical Support Operations	Reviewed	07/2021
Final Approval Date	**Final Approval**	**08/2021**

Describe briefly the most recent revision made to this policy, procedure or protocol & why:
Two similar policies retired Discharge planning for PMC and content contained in this policy. Several ORS were renumbered.

Policy Content

Purpose/Policy Statement:
Incorporates related requirements to discharge planning for inpatients hospitalized for mental health treatment, the required communication to lay caregivers, and clarifies the disclosure of Protected Health Information (PHI).

It is the policy of Salem Health to engage in discharge planning for inpatients hospitalized for mental health treatment. Discharge planning is addressed by a multidisciplinary team beginning at admission and continuing throughout a patient's hospital stay to support timely discharge, effective post-discharge care and documented in the medial record. This policy is available on the hospital's website and in the form of a brochure and will be given to patients upon admission and at discharge.

Steps/Key Points Procedure

A. Psychosocial Needs

1. Clinical Services begins the discharge planning process by completing a psychosocial assessment within three (3) business days of admission, to identify psychosocial and financial needs for successful discharge.
2. Defining the Lay Caregiver: hospitals must offer all inpatients hospitalized for mental health treatment the opportunity to designate a "lay caregiver." The "lay caregiver" will be referred to and documented in the medical record. .
    a. Ask the patient if they would like to identify a family member, friend, or other person as the lay caregiver per HB3090 to provide assistance to the patient following their discharge from the hospital. The lay care giver is not in the role of making health care decisions for the patient.
    b. Explain to the patient the benefits of identifying a lay caregiver which include participation in discharge planning and appropriate supportive measures.
    c. Explain to the patient only minimum information necessary will be shared with primary support person.
    d. Explain to the patient they have the ability to rescind the authorization at any time.

e. If a primary support person is identified, note the designation in the patient's medical record with the relationship to the patient.
f. If no primary support person is identified document none or refusal in medical record.

3. Clinical Services writes a discharge note in the medical record, indicating a summary of progress during hospitalization and discharge functional level.
4. Social Work and the Discharge Coordinator work with the patient, family, community partners and physician to identify resources for follow-up care within the community.
5. Social Work or the Discharge Coordinator writes a discharge note in the electronic medical record, indicating discharge placement and specific arrangements/referrals for follow-up care, as applicable.
6. Clinical Services writes a note in the electronic medical record indicating a summary of progress during hospitalization

B. Patient Authorization to Disclose Protected Health Information: Salem Health may disclose protected health information (PHI) only as authorized by the individual or as permitted under HIPAA.

1. In situations where the patient is given the opportunity and does not object, HIPAA allows the provider to share or discuss the patient's mental health information with family members or other persons involved in the patient's care or payment for care.
2. The health care provider may share or discuss only the information that the person involved needs to know about the patient's care or payment for care. Information to share with the patient and primary support person prior to discharge should include, but need not be limited to:
    a. The hospital's criteria and reasons for initiating discharge.
    b. The patient's diagnosis, treatment recommendations, and outstanding safety issues.
    c. Risk factors for suicide and what steps to take if danger exists, such as ridding the home of firearms/other means of self-harm and creating a plan to monitor and support the patient.
    d. The patient's prescribed medications including dosage, explanation of side effects, and process for obtaining refills, as applicable.
    e. Available community resources including case management, support groups, and others.
    f. The circumstances under which the patient or primary support person should seek immediate medical attention.
3. Please consult with the Privacy Officer if there are any concerns regarding releasing PHI to parents/family.

C. Medical and Physical Needs:

1. Conduct an evidenced based risk assessment of the patient's risk of suicide: Oregon law requires that a patient hospitalized for mental health treatment receive a suicide risk assessment prior to discharge. Providers must complete the suicide risk assessment in a timely manner so as not to delay discharge. The assessment should be included in the patient's medical record as part of the discharge plan.
    a. Providers should seek input from the patient's designated primary support person, if applicable. .
    b. Providers may accept unsolicited information from family and friends not authorized for disclosure.
2. At minimum, the assessment should help the provider determine:
    a. The patient's need for community based services:
    b. The patient's capacity for self-care.
    c. To the extent practicable, whether the patient can be properly cared for in the place where the patient resided at time of admission.

3. Coordinate the patient's care and transition to outpatient treatment. Providers should share the post-discharge treatment plan with the patient and one or more of the following: primary support person, community based providers, peer support, or other individuals who can implement the patient's care plan. Contact information for the outpatient care including address and phone number of the site/provider.
4. Schedule a follow-up appointment for no later than seven days after discharge.
    a. If a follow-up appointment cannot be scheduled within seven days, document the applicable barriers in the patient's medical record.
5. Provide Instructions or Training
    a. As necessary, provide instructions or training to the patient and primary support person prior to discharge, be provided at a level understandable to the patient and primary support person and ideally are provided both orally and in writing. Instructions or training may include assistance with activities of daily living, medical or nursing tasks such as wound care, administering medication, or operation of medical equipment, or assistance relating to the patient's condition.
6. Notify the designated primary support person in advance of patient discharge or transfer to another care setting and document in the medical record.
    a. The notice should be provided enough in advance to allow the primary support person to be present if necessary.
    b. Notice to primary support person(s) should never delay a patient's discharge.
7. Nursing is responsible for the coordination of discharge planning for medical and physical needs, in collaboration with the patient's psychiatric provider, Clinical Services and the Discharge Coordinator; discharge plans and teaching are started during the admission process and continue throughout the patient's hospital stay.
8. Nursing assesses patients' physical and medical needs at time of admission and on an ongoing basis. The Psychiatric Provider, Clinical Services and Nursing work together to ensure identification of, and recommendations regarding patients' physical and medical conditions and the need for follow-up as indicated.
9. Nursing, Psychiatric Provider and Pharmacy teach patients and families regarding medication effects and side effects, which is documented in the medical record. Psychiatric Provider may order nursing to complete a medication assessment to determine a patient's ability to self-administer medications as ordered.
10. Nursing teaches patients and families regarding physical and medical self-evaluation and care, such as wound care, blood sugar monitoring, administration of insulin, catheter care, dietary restrictions, etc.; this is also documented in the electronic medical record (EMR) patient education record.

D. Nursing & Clinical Services Responsibilities at Time of Patient's Discharge

1. Process for Discharge Medication Reconciliation:
    a. Patients are discharged from PMC to many locations, including home, shelters, group homes, alcohol and drug treatment programs, other hospitals, Salem Hospital ED, Salem Hospital medical floors, jails, Community Mental Health Care programs, private psychiatrists' offices, primary care physicians' offices, etc.
    b. The **PMC Psychiatric Provider prepares the AVS summary and completes the EPIC Discharge medication reconciliation form** and reviews the record, and will decide to continue/discontinue the medications or add new orders to the document—this must be signed with a date and time; **additionally, a prescription must be printed or e-scribed if needed, as the discharge medication reconciliation form is not the prescription order.**
    c. The **PMC RN goes over the discharge medication reconciliation with the patient, which will be a part of the discharge check list;** the patient will receive a printed copy of the AVS and a copy will be retained in EMR. Additionally, if needed, the Important Message for Medicare is provided and signed for. Suicide Risk Assessment and Vital Signs are completed within 4 hours of departure.

d. The **Outpatient COM building Pharmacist educates the patient by phone** about the discharge medications when medications are being ordered and filled by SH Pharmacy and assists in identifying any potential medication errors or interactions. Patient can take prescription to any pharmacy of their choice.
e. The **Discharge Coordinator faxes or sends a copy of the After Visit Summary (AVS), which includes the discharge medication reconciliation to the next provider** or location where the patient will receive health care.
f. The **Social Worker helps the patient in obtaining free medications,** if they meet certain criteria, or gives guidance regarding pharmacy assistance programs.
g. The **Unit clerk assists staff** in work that is delegated to them in order to accomplish medication reconciliation and also assists the weekend on-call physicians in orienting them to the procedure.

2. For all discharges to nursing homes or other care facilities, the provider, nurse and social worker complete the Nursing Transfer Form, summarizing the patient's status, including current problems, follow-up appointments, and/or treatments to promote continuity of care. AVS form accompanies patient at discharge.
3. If a supply of discharge medications needs to be filled, the Social Worker completes the authorization and forwards it to the Salem Hospital Outpatient/COM Pharmacy, to be filled prior to discharge; medications filled by Salem Hospital Pharmacy are dependent on the patient's insurance status or resources—if a patient chooses to have prescriptions filled outside of the Hospital, the patient is given written prescriptions upon departure from the unit. PMC staff may pick up medications or patient will pick up medication at the pharmacy after leaving PMC.
4. Nursing completes the After Visit Summary Instructions, prints the completed form and provides these to the patient.
5. Verify all patient belongings, home medications and valuables against the list on the Nursing Admission Data form upon return to the patient; the Charge RN checks the safe for valuables.
6. The patient signs the Patient's Valuables Deposit slip to indicate that all belongings have been returned.
7. Unit Clerk or CNA may be assigned to gather patient belongings and assist RN with discharge process.
8. Return all belongings to the patient or transporter, if appropriate.
9. Nursing notifies the PMC kitchen of the discharge.
10. Nursing notifies housekeeping that the room is vacant and requires cleaning.
11. Discharge is documented in Progress Notes in electronic medical record.

This policy will be available via the hospital website and copy provided to the patient upon admission and discharge in the form of a brochure or written summary of the policy that is easily understood in accordance with OAR 333-505-0055.

Definitions – Insert N/A if not applicable
• **Discharge** – the release of a patient from a hospital following admission to the hospital. • **Hospitalized for Mental Health Treatment** - patients admitted to psychiatric inpatient treatment. • **Lay caregiver** - a family member, friend, or other support person to provide assistance to the patient following their discharge from the hospital. Hospitals may use other terms to describe the functional role of the lay caregiver such as support person. Protected Health Information (PHI) – individually identifiable health information that is transmitted or maintained in any form or medium, including electronic, paper, and oral. • **Peer Support** – a peer support specialist, peer wellness specialist, family support specialist or youth support specialist.
Equipment or Supplies - Insert N/A if not applicable – N/A
N/A
Form Name and Number or Attachment Name - Insert N/A if not applicable – N/A
N/A
Expert Consultants Position -
Manager, Regulatory and Patient Safety Director, Corporate Integrity Safety & Risk
References (Required for clinical Documents) :
ORS 441.054, ORS 441.051, ORS 441.750, OAR 333-505-0030, 42 CFR 482.13(b)(5), 42 CFR 482.43. , CMS: 482.23(b)(4), OAR 333-510-0020, P.C.01.03.01
Policy, Procedure or Epic Protocol Cross Reference Information – Insert N/A if not applicable
Release of Information (ROI) Policy
Computer Search Words
Mental Health, Mental Health Treatment, Discharge, Discharge Planning, PMC, Psychiatric Medicine Center, Psychiatric Services.
Is there a Regulatory Requirement? Yes
Yes - ORS 441.054, ORS 441.051, ORS 441.750, OAR 333-505-0055, CMS: 482.23(b)(4), OAR 333-510-0020, P.C.01.03.01

Review and Revision History		
History	**Review or Revision**	**Date**
Two similar policies retired Discharge planning for PMC and content contained in this policy. Several ORS were renumbered	Revision	08/2021
No change at this time.	Reviewed	09/2019
OAR changed and moved to 333-505-0055 by OHA. Changes in policy to reflect changes in OARs.	Revision	11/2018
Revised due to OAR changes.	Revision	08/2018
New Policy		09/2016